Using a Preventive Social Work Program for Reducing School Refusal

Mohamed Mohamed Elsherbiny

This article describes a study aimed at solving the problem of school refusal by implementing a preventive program and raising the awareness of parents, social workers, and school personnel. The school children involved in this study were reported by their parents and school social workers to refuse to go to school, and according to the children's and parents' scores on a refusal scale. A random sample of size $N = 48$ was chosen according to the simple random sample method from the population of 77 students who were determined to refuse to go to school. The sample was divided randomly into experimental and control groups, 24 each. The experimental group went through a preventive intervention program, whereas the control group did not. The quantitative results showed a significant difference between the experimental and the control groups. The qualitative results showed an increase in school attendance and participation in school activities, and improvements in school performance. Accordingly, the prevention program can be deemed effective in decreasing school refusal.

KEY WORDS: *intervention; prevention; preventive social work; school refusal*

Recently, school refusal behavior (SRB) has been receiving more attention, and many researchers have begun to study its causes and looking for ways to prevent and treat it. At the present time, the problem of students refusing to go to school is known as school refusal; in the past the term "school phobia" was used (Wimmer, 2008). "School refusal" is an inclusive term, and school phobia is considered a subcategory of SRB (Kearney, 2008). School refusal is prevalent, as about 1 percent to 5 percent of school children refuse to go to school, particularly children who are between five and seven years old (Sewell, 2008). Research shows no differences between genders regarding school refusal (Heyne, King, Tonge, & Cooper, 2001). Also, the symptoms of the school refusal usually appear in the morning and disappear when the child is at home (Sewell, 2008).

Our study developed a preventive social work program as a strategy to prevent school refusal. "Prevention refers to strategies or programmes that prevent or delay the onset of health and behaviour problems. It also refers to strategies that reduce the harms and health consequences of behaviours that have been initiated" (Walker, 2005, p. 8).

CHARACTERISTICS AND SYMPTOMS OF SCHOOL REFUSAL

There is a relationship between school refusal and separation anxiety (Finberg, 2007), performance anxiety, social and generalized anxiety, depression, bullying, and health-related concerns (Wimmer, 2010). Usually, school refusal has somatic symptoms such as headache, abdominal pain, nausea, and shakiness or dizziness, whereas separation anxiety has fussing and crying as basic signs. Also, screaming and tantrums may occur (Sewell, 2008).

School refusal has both short- and long-term consequences. Short-term effects include school difficulties, family problems, and poor communication with others. Long-term effects may include school dropout, unemployment, and even psychiatric illness (Sewell, as cited in Maeda, Hatada, Sonoda, & Takayama, 2012). To prevent many of these negative effects, a preventive social work program can be implemented to deal with SRB.

Preventive Social Work Program

Prevention has emerged as an important component of health reform. Social work, with its extensive involvement in the health system and deep roots in public health, can provide a better understanding of

doi: 10.1093/cs/cdx005

its role in prevention (Ruth, Velásquez, Marshall, & Ziperstein, 2015). Preventive social work is important because it intercepts the cause of malfunctioning or the problem and deals with risk factors that cause harm for children and families.

Prevention mainly includes activities used to alleviate or overcome a psychological problem (Walker, 2005) after beginning symptoms are presented; these activities obstruct the further development of social problems. Prevention is important as it protects individuals from experiencing many health or behavior problems and provides support to help them achieve their goals effectively (El-Bassel, 2008). It also refers to strategies related to the prevention or delay of the beginning of health and behavior problems (Walker, 2005).

Three distinct levels of prevention can be identified (Sheafor, Horejsi, & Horejsi, 2000): Primary (level 1) prevention reflects actions intended to prevent the problem from developing. Secondary (level 2) prevention describes actions intended to detect a problem in its early stages and address it while it is still relatively easy to do so. Tertiary (level 3) prevention requires actions intended to address an already existing problem in ways that prevent it from spreading to others, expanding the damage and becoming even worse. Most social work practices focus on secondary and tertiary interventions, which are designed to alleviate the effects of problems after they had already arisen (Marshall et al., 2011).

Addressing School Refusal Early

School refusal is a serious issue that should be handled as early as possible, because of very serious consequences (see, for example, Kearney, 2006; Wimmer, 2010).

Short-Term Consequences. School refusal causes stress for parents and school personnel (Prabhuswamy, Srinath, Girimaji, & Seshadri, 2007). Also, it might cause a lack of appropriate academic achievement, inability to develop adequate social relationships, and family conflict (Perrotta, 2011; Wimmer, 2010).

Long-Term Consequences. "School refusal poses serious problems for the child's social, emotional, and educational development" (Prabhuswamy et al., 2007, p. 375). It also may lead to panic and emotional disorders in adulthood (Wimmer, 2003).

Literature Review

A good number of recent studies correlated a child's emotional or behavioral problems such as school refusal with family background (Chang & Romero, 2008; Henry, 2007; Maynard et al., 2015), whereas others have considered a wider ecological perspective (Dube & Orpinas, 2009; Heyne et al., 2001). Other studies discussed different terminologies such as assessment and treatment (Adeyemo, 2005; Kearney, 2006). Some studies focused on the types of school refusal (Wimmer, 2010); others dealt with the outcomes of such refusal (Wimmer, 2008).

Regarding prevention social work, some researchers indicated that there is a lack of interest in prevention within the social work practice (Marshall et al., 2011). However, it has been found that prevention programs in social work are effective in different areas. For example, in schools, a prevention program was successful in solving the problem of sexual abuse (Kernsmith & Hernandez-Jozefowicz, 2011), and in dealing with violence in prekindergarten (Allen, 2009). Also, the program was successful with all ages, including children (France, Freiberg, & Homel, 2010), adolescents (Noel, Rost, & Gromer, 2013), and older people (Manthorpe & Iliffe, 2011). Other groups who responded successfully to a prevention program successfully included people dealing with delinquency (Koffman et al., 2009), homelessness (Manthorpe, Cornes, O'Halloran, & Joly, 2013), and family issues (McGhee & Waterhouse, 2011).

HYPOTHESES

The present study posited one main hypothesis and four subhypotheses. The main hypothesis was that a preventive social work program would decrease school refusal.

Four subhypotheses emerged from the main hypothesis: (1) The program would decrease avoiding stimuli that provoke negative affectivity. (2) The program would decrease aversive social situations. (3) The program would decrease pursuing attention from significant others. (4) The program would decrease pursuing tangible forces outside the school.

METHOD

Sampling Procedure

To meet the international ethical professional guidelines, I obtained written permissions from the Future Language School in Assiut, Egypt, and the undersecretary of the Ministry of Education. All

students and parents involved in the study provided their written consent.

A list of schools that included a private kindergarten program in the city of Assiut, Egypt, was prepared. I chose one school with the highest number of students (77) exhibiting SRB (according to school records). Out of these 77 children, five children were not included because their parents work overseas and two more children were not included because their parents were divorced. Also, eight parents declined to participate (without giving a specific reason) and another four parents also declined to participate for personal reasons. From the remaining 58 children, 48 were chosen randomly (according to simple random sampling), 28 boys and 20 girls. Both the children and their parents completed a version of the School Refusal Assessment Scale-Revised (SRAS-R) (Kearney, 2002), SRAS-R-C (child) and SRAS-R-P (parent), respectively, in one session, each group in a separate quiet room. The children completed the scale with the help of a social worker and a psychologist. Then, the children were divided into two groups: the experimental group (24 children) went through program intervention and the control group (24 children) did not go through the program. The control group served as an untreated comparison group, receiving an intervention at a later date.

The prevention program lasted for one year (September 2011 to September 2012). The follow-up was conducted six month later (March 2013).

Program Description

The program started after we determined that the child met the criteria for school refusal, based on school record, teacher and social worker records, parents, and the result of SRAS-C-R and SRAS-P-R (Kearney, 2002).

The program included three different phases. The first phase aimed to respect the children's feelings and help them to return to school. This phase included the following activities:

- The children were encouraged to express their views regarding school to find out the reasons for school refusal.
- The children were helped to overcome negative feelings regarding school gradually.
- The children were assured that their families would be safe during the school day. They were given moral support using different intervention strategies. This activity is important because children may have fears about separating from their family (Perrotta, 2011).

During the second phase we worked with family members to convince them of the importance of intervening in the school refusal problem. There is some evidence that families play an important role in causing the problem (Department of Child and Adolescent Psychiatry, 2015).

The third phase introduced work with school teams: Children were examined for physical wellness. Children were encouraged to communicate with school personnel. Children also received rewards for going to school.

In addition, the following steps were followed (Wimmer, 2003): Teachers were trained to identify the signs of school refusal and apply useful strategies to take early action, for example, giving parents guidelines, reinforcing positive behaviors, and ignoring negative ones.

Teachers were trained to help children when they arrive at school to become organized for the school day. Children were helped to feel comfortable at school when they completed school tasks.

All three phases were conducted under the supervision of a professional with a PhD in social work and experience in dealing with problems that may face children.

Strategies and Techniques

Several techniques were used during the study such as modeling, cognitive restructuring, shaping and differential reinforcement, extension, contingency contracts, use of monitoring systems, desensitization, and increasing social support.

Instrumentation and Administration

Instruments were administered at the baseline, after one year, and at the follow-up phase (six months after the intervention). I interviewed all the subjects and parents at each stage. SRAS-R (Kearney, 2002) is a 24-item measure of the relative strength of four hypothesized functions of SRB in children. It is designed to support a four-factor model to assess school refusal, which includes functions aimed to "(a) avoid stimuli that provoke a sense of general negative affectivity, (b) escape from aversive social situation at school, (c) pursue attention from significant others, and (d) pursue tangible

reinforcement outside the school setting" (Kearney, 2002, p. 235).

Test–retest reliability across seven 14-day intervals for the four SRAS-R-P functional condition scores has been found to be .63, .67, .78, and .61, respectively. All SRAS-R-C and SRAS-R-P items also displayed statistically significant test–retest reliability. All values represent Pearson coefficients and are statistically significant (Kearney, 2002).

Validation of the SRAS-R has been conducted using two samples of children and adolescents with a combined sample size of 168 (n = 115 and 53, respectively) (Kearney, 2002). Findings from this validation study indicated adequate to good inter-item correlations for both the parent and the child versions of the SRAS-R (Kearney, 2002).

Procedure

Teachers were given information about the signs of school refusal to observe from the children behaviors. Also, during the interviews with the parents, school refusal signs were identified.

After all information and evidence were collected, we calculated the score of refusal scale of parents and children and considered this as the baseline score. For both the experimental and the control groups, the scale was applied before the intervention (baseline B), after one year (stage A), and at follow-up after six months (follow-up F).

Intervention Implementation

Treatment was divided into three phases (30 sessions for each child, each session lasting for 20 to 30 minutes).

First Phase: Cognitive Modification of Attribution (Sessions 1–7). The aim was to identify the negative attitudes toward school and negative consequences, and to identify the negative thoughts that led to the development of such negative attitudes, thereby increasing the motivation for cognitive change.

Second Phase: Behavioral and Social Skills Training (Sessions 8–17). The aim was to develop the positive attitudes toward school and its positive consequences. The children were trained to acquire positive behaviors that take place while they were at school and having a good time with their friends, teachers, social workers, and so on, using different types of positive activities.

Third Phase: Relapse Prevention and Sustainability (Sessions 18–30). The aim was to strengthen and reinforce the positive cognitive thinking by rewarding positive actions and ensuring readiness to deal with future problems.

Statistical Analysis

The t test was applied to show the difference between two means to test the research hypotheses using SPSS software (version 16). The results are shown in Tables 1 through 6.

RESULTS

To ensure accurate error coverage, Bonferroni Correction was used. The chance of finding one or more significant differences in hypothesizes testing is = 0.0394 (3.94 percent).

In looking at each of the four subhypotheses (see Tables 1–4), there are no statistically significant differences, at the .01 level of significance, between control and experimental groups before the intervention in school refusal, but there are statistically significant differences between control and experimental groups after intervention and at follow-up.

Among the control group, there was no significance difference between baseline and at the end of the study, and also between the baseline and at follow-up (in the four dimensions) (see Table 5). Among the experimental group, there was a significance difference between the baseline and after the intervention, and also between the baseline and at follow-up (in the four dimensions).

Table 1: Results of t Tests for Control Group (n = 24) and Experimental Group (n = 24) for Subhypothesis 1

	Control Group		Experimental Group			
Stage	Range	*M (SD)*	Range	*M (SD)*	*t*	Significance
Before intervention	3.83–5.1	4.56 (0.43)	4.33–5.38	4.91 (0.29)	2.37*	Not significant
After intervention	4–5.05	4.59 (0.33)	2.66–3.27	2.94 (0.17)	21.7	Significant
At follow-up	4–5.05	4.58 (0.3)	2.71–3.13	2.94 (0.11)	24.64	Significant

*p < .01.

On the basis of school and teacher records, it was obvious that

- There was an increase in school attendance (based on school attendance record).
- There was an increase in participation in social activities (based on social work records and feedback from teachers).

These records indicate that school performance improved more among the experimental group than the control group. Number of absences decreased among the experimental group. Physical symptoms such as abdominal pain, nausea, dizziness, and diarrhea diminished among the experimental group (this finding is based on the records from the nurse at school and feedback from parents at home). The experimental group grew to love school, and sometimes they felt sad to go home at the end of the day (according to reports by parents). Teachers were happy to see that the experimental groups became more acquainted with

Table 2: Results of *t* Tests for Control Group ($n = 24$) and Experimental Group ($n = 24$) for Subhypothesis 2

	Control Group		Experimental Group			
Stage	Range	*M (SD)*	Range	*M (SD)*	*t*	Significance
Before intervention	4.16–5.5	4.67 (0.35)	4.77–5.23	4.97 (0.14)	2.79*	Not significant
After intervention	4.33–5.33	4.77 (0.27)	2.71–3.13	2.95 (0.15)	28.2	Significant
At follow-up	4.5–5.05	4.75 (0.18)	2.66–3.13	2.95 (0.15)	37.6	Significant

*$p < .01$.

Table 3: Results of *t* Tests for Control Group ($n = 24$) and Experimental Group ($n = 24$) for Subhypothesis 3

	Control Group		Experimental Group			
Stage	Range	*M (SD)*	Range	*M (SD)*	*t*	Significance
Before intervention	4.5–5.5	5.04 (0.28)	4.94–5.66	5.24 (0.21)	1.94*	Not significant
After intervention	4.5–5.33	5.02 (0.27)	2.88–3.13	3.01 (0.09)	34.18	Significant
At follow-up	4.66–5.27	4.96 (0.21)	2.71–3.1	2.94 (0.11)	42	Significant

*$p < .01$.

Table 4: Results of *t* Tests for Control Group ($n = 24$) and Experimental Group ($n = 24$) for Subhypothesis 4

	Control Group		Experimental Group			
Stage	Range	*M (SD)*	Range	*M (SD)*	*t*	Significance
Before intervention	4–5.16	4.68 (0.41)	4–4.94	4.53 (0.33)	1.02*	Not significant
After intervention	4–5.16	4.66 (0.31)	2.66–2.94	2.78 (0.11)	27.3	Significant
At follow-up	4.33–5.05	4.71 (0.21)	2.53–3.05	2.8 (0.15)	36.45	Significant

*$p < .01$.

Table 5: *t* Values to Compare the Cases Before and After Intervention and at Follow-Up in Control Group

	Subhypothesis 1		Subhypothesis 2		Subhypothesis 3		Subhypothesis 4	
Stage	B	A	B	A	B	A	B	A
B		0.30		0.98		.16		0.19
F	0.18	0.14	1.01	0.16	1.10	0.93	0.29	0.61

Notes: A = after intervention; B = before intervention; F = at follow-up.

Table 6: *t* Values to Compare the Cases Before and After Intervention and at Follow-Up in Experimental Group

	Subhypothesis 1		Subhypothesis 2		Subhypothesis 3		Subhypothesis 4	
Stage	B	A	B	A	B	A	B	A
B		28.37		48.56		47.02		23.98
F	30.57	0.14	48	0.14	46.73	2.1	23.00	0.39

Notes: A = after intervention; B = before intervention; F = at follow-up.

other children and communicated well with them instead of being isolated.

My main hypothesis was supported by many studies (Wimmer, 2003). Many studies also confirm subhypothesis 1 (Pina, Zerr, Gonzales, & Ortiz, 2009), subhypothesis 2 (Gosschalk, 2004), subhypothesis 3 (Perrotta, 2011), and subhypothesis 4 (Maynard et al., 2015). All of these studies showed the efficacy of interventions in the early stage of the problem for decreasing SRB and its components. The results of the current study also demonstrate that a preventive social work program plays an important role in decreasing school refusal among young students.

DISCUSSION

The present study intended to identify the effects of a prevention social work program in decreasing SRB among children between the ages of four and six years. The findings underscore the positive effects of a preventive social work program with regard to children who suffer from the problem of school refusal. The program effectively and significantly decreased four dimensions of school refusal in the experimental group. To further underscore the effectiveness of the program, there was no difference in the control group in all stages.

The improvements seemed to be a direct result of the implementation of the preventive program strategies and the outcome of teamwork. We were assured that in case of unexpected situations during the application of the intervention program, we should be consulted. A report should be written weekly about the cases to help in the process of evaluation. Furthermore, there were significant changes indicated in the outcomes measures.

The application of the scale at baseline and the observation stages for all children in both groups showed a high degree of school refusal at the beginning. These results are compatible with many previous studies that dealt with acute refusal (see, for example, Gosschalk, 2004). The interviews with parents at baseline showed that the cause of the problem might be attributed to the mother–child relationship, overprotection, or parents' styles of socialization as indicated by parents.

At baseline, most of the students exhibited many signs of school refusal, such as somatic complaints, and this reflected their fearfulness and the lack of an appropriate school environment. Thus, one aim of the intervention program was to create a welcoming school environment. At follow-up, the signs of such problems disappeared among the experimental group.

Research has shown that family might be a factor in increasing SRB (Chang & Romero, 2008; Henry, 2007; Maynard et al., 2015), so clear instructions were given to the family and parents to deal with the school refusal as a serious issue, and parents were taught how to deal with the child through encouragement and rewards instead of using verbal threats or physical punishments.

Although the rates of school refusal in Arab countries seems to be high (6 percent to 8 percent) (Directorate of Education, 2012), it is not far from the world rates (1 percent to 5 percent) and similar to U.S. rates (5 percent) (Sewell, 2008).

In summary, the present study agreed with other studies around the world and in the United States indicating that SRB is effectively treated through different techniques and interventions: cognitive–behavioral strategies in China (Wu et al., 2013); behavioral treatment in Australia (Gosschalk, 2004); psychological intervention in Spain (Bragado, 2006); and parent–teacher interventions (Adeyemo, 2005), problem solving (Kearney & Bates, 2005), and psychosocial and family-based psychosocial intervention in the United States (Kearney, 2006).

Limitations

The findings in this research should be interpreted in light of the following limitations:

- The sample size is small for both the experimental ($n = 24$) and the control ($n = 24$) groups.
- The age range of the children was between four and six years.
- The school used in the study is classified as a private school, and its tuition is normally higher than governmental school. In addition, the school is located in Upper Egypt, and results are not generalizable to other contexts.
- The level of education of the parents varied from high school education to college education, which may have affected the results of the study.

It could be argued that other factors that were not controlled for may have influenced the results of this study:

- child-related factors such as level of anxiety, the order of the child in the family, and whether the child attended preschool;
- parental-related factors such as family size, types of socialization, economic status, and parents' level of education;
- school-related factors such as peer grouping and level of staff support.

Implications for Policy and Practice

The findings of this study have a number of implications regarding the school practice with children exhibiting SRB, such as raising awareness of the problem among both teachers and families, avoiding future problems such as academic failing (underachievement), and avoiding social problems with other friends. Also, the findings of the present study can help families with children to identify the signs of school refusal and also help them to prevent the problem before their children attend school (primary prevention). School policies that support the identification of school refusal should be embraced by school leadership in Egypt. There is a need for further application of prevention programs for older children who experience SRB. Other studies should be conducted with a longer period of follow-up to explore what happens after intervention and to screen for relapses.

Conclusion and Recommendations

The results of this study showed that for the experimental group, there was an increase in school attendance and participation in school. Absences and the physical symptoms of school refusal decreased. Preventive social work programs can play an important and effective role in decreasing school refusal.

Thus, there is an urgent need to increase public awareness about school refusal and how to deal with it. Interaction with children's families during intervention should be respectful and take into consideration the families' cultural values and beliefs. CS

REFERENCES

Adeyemo, D. (2005). Parental involvement, interest in schooling, and school environment as predictors of academic self-efficacy among fresh secondary school students in Oyo state, Nigeria. *Electronic Journal of Research in Education Psychology, 3*(1), 163–180.

Allen, S. F. (2009). A study of a violence prevention program in prekindergarten classrooms. *Children & Schools, 31*, 177–187.

Bloom, M., & Gullotta, T. P. (2008). Prevention. In T. Mizrahi & L. E. Davis (Eds.), *Encyclopedia of social work* (20th ed., Vol. 3, pp. 398–405). Washington, DC, and New York: NASW Press and Oxford University Press.

Bragado, C. (2006). Fobia escolar y rechazo al colegio [Scholastic phobia and school refusal]. In F. X. Méndez, J. P. Espada, & M. Orgilés (Eds.), *Intervención psicológica y educativa con niños y adolescentes: Estudio de casos escolares* [Psychological intervention with children and adolescents: Studies of scholastic cases]. Madrid: Pirámide.

Chang, H. N., & Romero, M. (2008). *Present, engaged and accounted for: The critical importance of addressing chronic absence in the early grades*. New York: National Center for Children in Poverty, Columbia University.

Department of Child and Adolescent Psychiatry. (2015). *School refusal: Good practice guide for schools*. Retrieved from https://www.education.ie/en/Schools-Colleges/Services/National-Educational-Psychological-Service-NEPS-/NEPS-Guidelines-Handouts-and-Tips/School-Refusal/School-Refusal.pdf

Directorate of Education. (2012). *Statistics of school phobia in schools*. Cairo, Egypt: Ministry of Education.

Dube, S. R., & Orpinas, P. (2009). Understanding excessive school absenteeism as school refusal behavior. *Children & Schools, 31*, 87–95.

Finberg, M. R. (2007). School refusal. In C. R. Reynolds & E. Fletcher-Janzen (Eds.), *Encyclopedia of special education: A reference for the education of children, adolescents, and adults with disabilities and other exceptional individuals* (3rd ed., Vol. 1, pp. 1803–1853). Hoboken, NJ: John Wiley & Sons.

France, A., Freiberg, K., & Homel, R. (2010). Beyond risk factors: Towards a holistic prevention paradigm for children and young people. *British Journal of Social Work, 40*, 1192–1210.

Gosschalk, P. O. (2004). Behavioral treatment of acute onset school refusal in a 5-year old girl with separation anxiety disorder. *Education & Treatment of Children, 27*, 150–160.

Henry, K. L. (2007). Who's skipping school: Characteristics of truants in 8th and 10th grade. *Journal of School Health, 77*, 29–35.

Heyne, D., King, N. J., Tonge, B. J., & Cooper, H. (2001). School refusal: Epidemiology and management. *Paediatric Drugs, 3*, 719–732.

Kearney, C. A. (2002). Identifying the function of school refusal behavior: A revision of the School Refusal Assessment Scale. *Journal of Psychopathology and Behavioral Assessment, 24*(4), 235–245.
Kearney, C. A. (2006). Confirmatory factor analysis of the School Refusal Assessment Scale-Revised: Child and parent versions. *Journal of Psychopathology and Behavioral Assessment, 28*(3), 139–144.
Kearney, C. A. (2008). School absenteeism and school refusal behavior in youth: A contemporary review. *Clinical Psychology Review, 28*, 451–471.
Kearney, C. A., & Bates, M. (2005). Addressing school refusal behavior: Suggestions for frontline professionals. *Children & Schools, 27*, 207–216.
Kernsmith, P. D., & Hernandez-Jozefowicz, D. M. (2011). A gender-sensitive peer education program for sexual assault prevention in the schools. *Children & Schools, 33*, 146–157.
Koffman, S., Ray, A., Berg, S., Covington, L., Albarran, N. M., & Vasquez, M. (2009). Impact of a comprehensive whole child intervention and prevention program among youths at risk of gang involvement and other forms of delinquency. *Children & Schools, 31*, 239–245.
Maeda, N., Hatada, S., Sonoda, J., & Takayama, I. (2012). School-based intensive exposure therapy for school refusal behavior. *Clinical Case Studies, 11*, 299–311.
Manthorpe, J., Cornes, M., O'Halloran, S., & Joly, L. (2013). Multiple exclusion homelessness: The prevention role of social work. *British Journal of Social Work, 7*, 1–13.
Manthorpe, J., & Iliffe, S. (2011). Social work with older people—Reducing suicide risk: A critical review of practice and prevention. *British Journal of Social Work, 41*, 131–147.
Marshall, J. W., Ruth, B. J., Sisco, S., Bethke, C., Piper, T. M., Cohen, M., & Bachman, S. (2011). Social work interest in prevention: A content analysis of the professional literature. *Social Work, 56*, 201–211.
Maynard, B. R., Brendel, K., Bulanda, J. J., Heyne, D., Thompson, A., & Pigott, T. (2015). *Psychosocial interventions for school refusal with primary and secondary school students*. Retrieved from https://www.campbellcollaboration.org/library/psychosocial-interventions-for-school-refusal-with-primary-and-secondary-school-students-a-systematic-review.html
McGhee, J., & Waterhouse, L. (2011). Locked out of prevention? The identity of child and family oriented social work in Scottish post-devolution policy. *British Journal of Social Work, 41*, 1088–1104.
Noel, L. T., Rost, K., & Gromer, J. (2013). A depression prevention program for rural adolescents: Modification and design. *Children & Schools, 35*, 199–211.
Perrotta, P. (2011, August 12). Effective strategies for treating school anxiety and school refusal. *Centers for Family Change Blog*. Retrieved from http://www.centersforfamilychange.com/blog/?p=67
Pina, A. A., Zerr, A. A., Gonzales, N. A., & Ortiz, C. D. (2009). Psychosocial interventions for school refusal behavior in children and adolescents. *Child Development Perspectives, 3*(1), 11–20. doi:10.1111/j.1750-8606.2008.00070.x
Prabhuswamy, M., Srinath, S., Girimaji, S., & Seshadri, S. (2007). Outcome of children with school refusal. *Indian Journal of Pediatrics, 74*, 375–379.
Ruth, B. J., Velásquez, E. E., Marshall, J. W., & Ziperstein, D. (2015). Shaping the future of prevention in social work: An analysis of the professional literature from 2000 through 2010. *Social Work, 60*, 126–134.
Sewell, J. (2008). School refusal. *Australian Family Physician, 37*, 406–408.
Sheafor, B., Horejsi, C., & Horejsi, G. (2000). *Techniques and guidelines for social work practice*. Newton, MA: Allyn & Bacon.
Walker, M. (2005). *The statutory social worker's role in prevention and early intervention with children* [21st Century Social Work series]. Retrieved from http://www.scotland.gov.uk/Resource/Doc/47121/0020808.pdf
Wimmer, M. B. (2003). *School refusal: Assessment and intervention within school settings*. Bethesda, MD: National Association of School Psychologists.
Wimmer, M. B. (2008). School refusal: Understanding the reasons that students avoid school is the first step in getting them to return. *Principal Leadership, 8*, 10–15.
Wimmer, M. (2010). *School refusal: Information for educators*. Bethesda, MD: National Association of School Psychologists. Retrieved from https://www.shorecollaborative.org/profdev/School%20Refusal%20-%20InformatiOn%20for%20Educators.pdf
Wu, X., Liu, F., Cai, H., Huang, L., Li, Y., Mo, Z., & Lin, J. (2013). Cognitive behaviour therapy combined fluoxetine treatment superior to cognitive behaviour therapy alone for school refusal. *International Journal of Pharmacology, 9*(3), 197–203.

Mohamed Mohamed Elsherbiny, PhD, *is assistant professor, College of Social Work, Assiut University, Egypt (on leave), and Department of Sociology and Social Work, College of Arts and Social Sciences, Sultan Qaboos University, Muscat, Oman; e-mail: addasherb@yahoo.com. Address correspondence to Mohamed Mohamed Elsherbiny, P.O. Box 42, Al-Khod, 123 Muscat, Sultanate of Oman.*

Original manuscript received April 7, 2016
Final revision received August 30, 2016
Editorial decision September 26, 2016
Accepted September 28, 2016
Advance Access Publication February 13, 2017

PRACTICE HIGHLIGHTS

Share your practice experience providing exemplary services to individuals and families in school settings, especially involving interdisciplinary collaboration. Provide a brief review of the literature and tell how what you did builds on it, describe your program, and indicate what you learned from your experience. Articles should be typed double-spaced and no longer than six pages. Send your Practice Highlights column as a Word document through the online portal at http://cs.msubmit.net (initial, one-time registration is required).